KEYNOTE ADDRESS

DONNA E. SHALALA, PHD

INTRODUCTION BY KAREN DAVIS, PHD

An old saying has it, "You can't go home again," but the Honorable Donna Shalala is the exception. Secretary Shalala began her career in New York City in 1970, when she had completed her doctorate at the Maxwell School at Syracuse University, Syracuse, New York, and came to New York City as an assistant professor at Baruch College. Within 2 years, Dr. Shalala became an associate professor and chair at Teachers College at Columbia University.

Although her busy academic career was fulfilling, when the call came for public service, Dr. Shalala answered, becoming Assistant Secretary for Policy Development and Research at the Department of Housing and Urban Development, where she served between 1977 and 1980. Her dedication to public service has always been a hallmark of her academic career, and her ties to both Washington and New York have always been strong and intertwined. Dr. Shalala served New York City when others were telling it, in the words of one famous newspaper headline, to "drop dead." She served as a member of the Municipal Advisory Board, which helped New York to come back from its disastrous fiscal slide.

Dr. Shalala served as professor at Hunter College and as president of that institution from 1980 through 1988, until the University of Wisconsin at Madison recruited her to become chancellor there in the late 1980s to early 1990s. When another call came from Washington, Dr. Shalala answered again, this time to serve President Clinton as Secretary of Health and Human Services, where she remains today the longest serving HHS Secretary in the cabinet.

Throughout Secretary Shalala's long and varied career, one quality has always stood out: her caring for those who are poor, vulnerable, and at risk in this society. In her current post, she has been a champion in advocating improved health care and research on issues ranging from child health, to women's health, to the prevention and treatment of AIDS. She has also had a long association with the Commonwealth Fund, dating back

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to her stint at Hunter College, when she helped Margaret Mahoney launch the fund's youth mentoring work.

Secretary Shalala returned home to New York City to participate in the third annual Margaret Mahoney Symposium. It was my pleasure and my privilege to introduce her to the symposium, and I am delighted to share her thoughts with the readers of the Journal.

As I remarked at the beginning of my address at the third annual Margaret Mahoney Symposium, I am delighted to participate in anything named for Margaret Mahoney. Our collaboration began when, as I noted then, I had the chutzpah to visit Ms. Mahoney and say, "I run the neighborhood school down the street. There's got to be some way we can do a project together." And we did. Margaret Mahoney, who has always been a woman ahead of her time, worked very closely with us and came up with an idea for mentorships for very young people, to put caring adults into their lives. She wrote a brilliant essay on mentorship then and helped us to develop a program that still influences the lives of its participants. I still meet young people around the country who were part of the early Hunter College program, as well as people who were involved in the expanded national program.

Margaret Mahoney has not only touched the lives of young people, but also some of the adults, like myself. All the while, she has left deep footprints throughout her distinguished career on a variety of different subjects, whether it is science, medicine, or health, and has brought new attention and compassion to the lives of women, of children, of people of color, of the disabled, of the poor, those too often left out in the cold. That is why I was so delighted to participate in the symposium that honors her.

OUT IN THE COLD: EXCELLENT HEALTH CARE DENIED

It has become almost trite to observe that changes are taking place in the health care delivery system. Yet, those changes are far-reaching. There is an explosion of information, of technology, and new delivery systems. More and more consumers are playing a role in their own health care. Biomedical research is raising not only new hopes, but new ethical dilemmas. As this country ages, a huge shift from acute to chronic care is occurring, and a revolution in organized care is under way. I believe that that revolution, if done right, can be good medicine for the nation's health and economy. Yet, in the middle of these revolutions, more and more Americans are locked out of the best health care system in the world as the ranks of the uninsured have swelled to more than 40 million. Ten million of the uninsured are children; more than 600,000 of those children live in New York City. Problems of persons in need are often amplified in cities like

New York. These problems call for commitment and impatience: we must be more impatient about giving all Americans access to high-quality health care.

We live in a time when there is great concern about balancing the nation's budget. Let me be clear. I do not think that the issue is about whether the US will get to a balanced budget. The question is, Can we get to a balanced budget without endangering the health of our citizens, particularly the most vulnerable? How do we make health care changes for the 21st century while still keeping the promises that Franklin Delano Roosevelt of New York made in this century or without violating the commitments that Lyndon Baines Johnson of Texas made in this century? How do we change without changing who we are and what we believe in? At this time and place, how do we make certain that our citizens have access to quality health care, whether or not they have insurance?

CURRENT STEPS TO ENSURE HEALTH CARE TO THOSE IN NEED

The first step that must be taken, in my opinion, is to reform Medicare and Medicaid so that the historic protections they have given to our parents and our grandparents will be there for our children and for every generation. With Medicare, the immediate crisis we face, of course, is the solvency of the Hospital Insurance Trust Fund. In April 1997, the Medicare trustees, of whom I am one, reported that unless Congress enacts legislation, the trust fund will be depleted in the year 2001. For the past few years, we have put solid proposals on the table to save the trust fund in the short term and suggested a process for the long term. At the time of the Margaret Mahoney Symposium, for the first time, we seemed to have the outline of a bipartisan agreement to deal with the short-term problem.

The outlines of that agreement would reduce Medicare spending by $115 billion over 5 years. It would shift home health care expenditures from Part A to Part B, and it would extend the life of the trust fund until the year 2008. We insist on doing that, although without significantly shifting cost to the beneficiaries.

Saving Medicare in the short term, however, is not enough. We need a sophisticated strategy to modernize and strengthen the program. We need a longer-term strategy. We cannot move into the next century with a Medicare program that is not adequate for the demands that will be imposed upon it.

And so, over the last 4 years, led by Bruce Vladeck,* we have looked carefully at what is working in the private sector and have tried to apply some of those lessons to rein in costs and strengthen our programs for beneficiaries and providers. Beneficiaries now have more choices for care. Enrollment in some kind of organized care has increased more than 100%, and we are beginning to ensure

*Recipient of the Margaret E. Mahoney Award in 1996. See *Bull NY Acad Med.* 1996(suppl);73:602-606.

that those who choose managed care get quality care. The nursing home standard regulations that we put in place are the strongest in American history, and Operation Restore Trust, our antifraud program, has created a zero tolerance for health care fraud and abuse. Because of it, we are now recovering $10 for every $1 we invest.

Our new rules will require home health agencies to conduct background checks on all employees and use standards to measure the quality and outcomes of patient care. For the first time, we will bar felons from participating in the Medicare program, even those who were not convicted for health care fraud. The Secretary of Housing and Urban Development will have the authority and the flexibility, for example, to bar those that were convicted of securities fraud; this authority is important, as we increasingly find that those who have been convicted of fraud in one sector are now moving into the Medicare program.

We have moved to an electronic payment system and now lead the industry in the proportion of claims paid that way. We have used our demonstration authority to test innovative strategies, such as the Centers for Excellence. We think that these measures have improved care, lowering costs, in some cases, by as much as 12%. We have put forth a series of proposals that would make the kind of structural change that Medicare needs to bring it into the 21st century. We know how important prevention is, for example, in saving lives, yet Medicare is virtually alone in covering so few prevention benefits.

I predict that we will achieve a bipartisan agreement to bring the benefits package up to date in Medicare with medical practice and science. In addition to the influenza immunization benefit that was added in 1993, the current agreement includes hepatitis shots, annual mammograms, diabetes management, and screening examinations for prostate cancer. As the budget moves through the reconciliation process, we are hopeful that Congress will adopt our most critical structural reforms.

Some say that the budget agreement ducks the hard choices. I disagree. We give consumers two new choices in their health plans: provider-sponsored networks and preferred-provider organizations. We carve out medical education and disproportionate care payments from the current Medicare HMO [health maintenance organization] reimbursement formula, which allows us to make those payments directly to academic health centers. We make Medicare a much more prudent purchaser of health care services. This capability is especially important because heretofore we have been paying the highest price, not the lowest price, in the market, and too often, these prices have no relation to a product's fair market value.

We want to harness Medicare's enormous purchasing power to eliminate the outdated statutory rules so that we can use competitive bidding and other market

mechanisms to change the way that we pay providers and obtain the best possible prices for health care services. The way in which we pay needs a substantial overhaul for almost every service. For home health services and skilled nursing facilities, our goal is to create a prospective payment system. For managed-care plans, we want to reduce the geographical variation in current payment rates and find ways to inject competition into the bidding process.

For more of such accomplishments to happen, we must be willing to change, to be more creative, to be more efficient. We must do so to improve our bottom line of cost and the much more important bottom line, the health of older Americans and the disabled.

MORE MUST BE DONE

Just as Medicare has changed what it means to grow old or disabled in America, Medicaid has changed what it means to be poor in America, to be disabled in America, to be a sick child in America, to be HIV positive in America, to be a pregnant woman in America. From the beginning, our strategy was to create a Medicaid program that holds down costs while keeping and expanding our promises to citizens in need. Because we have closed loopholes, we have already brought the baseline in Medicaid down by $89 billion over 5 years. Enrollment in Medicaid managed care has increased by more than 170% since 1993. We have made it clear that we think that some state flexibility and disproportionate share reforms are the best way to hold down costs. We are looking for ways to use Medicaid and other programs to help give people living with HIV earlier access to promising drugs and life-saving care, and we have granted Section 11–15 demonstration waivers, which are giving 15 states additional flexibility to test innovative health care reforms. We hope that we are at the end of our negotiations with New York, where, as in other states, we have sought to protect the most vulnerable as part of the negotiating process on that waiver. I think that most of the advocates that have been talking to us will be pleased with the results of this very long process.

By means of the waiver process, we have, in fact, extended health insurance to 2.2 million more people in this country. The gap is closing, albeit slowly.

Even as we made those changes, our commitment to Medicaid's federal guarantee has never wavered. When Congress tried to block-grant Medicaid in 1996, the President drew a line in the sand and said no. With this year's budget agreement, the President held that line, and the neediest Americans have kept their health care.

When it comes to keeping our health care promises, Medicaid and Medicare are only part of the story. The fact is, health insurance is out of reach for too many working poor families and children. The Kennedy-Kassenbaum Bill did

help. It helped those who already had insurance by ensuring that they would not lose it because of a pre-existing condition or because they would not change jobs.

We have an agreement with Republican leaders to reduce the number of uninsured children in this country. As the President said in his State of the Union address, "No child should be without a doctor just because their parent is without a job." I would add to that the more important argument: no child in this country should be without a doctor just because their parent has a job.

As noted earlier, 10 million children have no health insurance. Nine out of 10 of those children come from working families. While the details are still unclear, because we need to negotiate them, our commitment is very clear. We intend to find a way, before we end this century, in which every American child has access to good-quality health insurance.

Why do these children not have health insurance? Sometimes their parents are embarrassed by the stigma of Medicaid. Sometimes they do not have employer coverage, but they themselves are covered. Sometimes they are moving in and out of the job market and are over or under the Medicaid line, which, after all, is merely a line drawn at some poverty level.

This is why our proposals bring together health plans, employers, states, health care professionals, and a group of public and private leaders, who will unite, we hope, in an unprecedented effort to attack the issue of children's health insurance from every direction. One desired outcome is to provide to children who qualify for Medicaid 1 year of continuous coverage, a provision modeled after the Head Start programs, wherein children enrolled in the program remain in the program for a full year, even if the parent's income changes. We believe that, when we enroll a child in Medicaid, we should allow that child to remain enrolled for the full year and then transfer her or him to another program. This proposal does that.

Other proposals, in addition to ours, integrate both the public health programs of the department and seek to identify those who now are eligible for Medicaid but do not have Medicaid. The proposals add some resources that seek to enable the states to assemble programs that will extend care to working-class children. Similar or variations on the themes are seen in proposals from Senators Kennedy, Hatch, Specter, Chaffey, and Rockefeller, and from Representatives Jeffers, Dingle, and Rokama: all attempt to identify children who come from working families that do not have access, as well as the 3 million American children who are eligible for Medicaid that are left out of the system one way or another.

One of the principal reasons that some stay on welfare is that they need health insurance for their children. That is why our central strategy on welfare reform has always been to make work pay, by expanding the earned income tax credit

(EITC) and increasing the minimum wage. It is very interesting that half of the states at present, as part of their own programs of welfare reform, include at least 2 years of Medicaid as someone moves from welfare to work. We also have increased substantially the monies for child care and have attempted to ensure that working parents who are not eligible for children's tax credits have access to health insurance for their children. We believe that such measures may make a difference in stabilizing people in the workforce; that it makes sense to combine the EITC with minimum wage increases, with child care, with transportation, with education and training, and with health insurance for children of the working poor and, ultimately, for the working poor themselves. It makes sense because, if all those pieces are put together and if entry-level jobs are reshaped, workers will know from their own experience that work actually does pay, and that one is better off in the workforce, even in an entry-level job, than under even the previous welfare system.

When the President signed the welfare bill, he said it was the beginning, not the end. He has kept some of the most important promises. The administration fought to restore health insurance for legal immigrants and for those sitting in nursing homes, the elderly, the aged, and the children. We have made good on our promise to restore many of those benefits. We are adding another $2 billion; hopefully, most of it will go to large cities to help them create some of the jobs that we will need in the system.

THE CHALLENGE: PROVIDING A HEALTH CARE SYSTEM THAT AMERICANS DEMAND

We must work together to ensure that high-quality care is always our bottom line, not only for vulnerable Americans, but for all Americans. Some say that quality is not a valuable commodity in today's tough marketplace. They should look at the rebirth of the American automobile industry. Quality sells because that is what consumers are demanding today. In her new book, Regina Hertzlinger[1] predicts that future changes in our health care system will be driven by consumer demands.

It is demonstrable that patients are no longer waiting for their physicians and health plans to tell them what to do. They are asking difficult questions; they are surfing the Web; they are calling 800 numbers; they are reading articles; they are comparing plans; they are talking to friends. I witnessed a demonstration of this concern only 2 hours before my address to the Margaret Mahoney Symposium, when I stood with the Vice President and we announced a new food safety initiative. One of the mothers that spoke was a parent of a child who was infected with *E. coli;* she reported that, after rushing her child to the hospital and consulting with all the specialists, who diagnosed the child's illness and told the parents that they really had a great deal to worry about, she and her husband logged

on to the Internet and found everything they could about that particular disease. The mother told the Vice President that she and her husband found out more in a couple of hours of searching the Web than any doctor was willing to tell them. The new second opinion is going to be the Internet.

Consumers are listening, are becoming more sophisticated, and are demanding lower costs and higher quality. That is what we must deliver, and we must make quality count economically.

That said, the question then becomes, What is quality in health care? Unlike obscenity, quality cannot be defined as, "I know it when I see it." Taking our cue from science, we must, therefore, give to Americans the tools they need to measure quality, and to compare quality, not simply by focusing on process, but by using our best research to measure real outcomes and real consumer satisfaction across all providers. We must do this, and more, because people are worried about their health care. They are worried about their health care plans. They are worried that the quest for profits will leave them without the care they need. They are worried about whether Medicare and Social Security will be there for them. I have seen this worry first hand; in fact, on a recent airline flight, the stewardess took a picture of the people lined up to talk to me as I sat in an aisle seat. There were only four people lined up for the bathroom; nine people were lined up to talk to me.

Although I believe in the power and the potential of organized care, we must make certain that the new ways of organized care are one and the same. I cochair, with Alexis Herman, Secretary of Labor, the President's Commission on Quality in Health Care. The commission holds meetings all over the United States. At the top of our agenda is writing a consumer bill of rights, so we can tell health care consumers what they are entitled to, such as the right to appeal when care is denied and the right to open communications with their doctor. We believe that such fundamental rights should obtain whether a person has health insurance or not, even when one interacts with the health care system without insurance. The elucidation of those rights will be an early product of the commission. Subsequently, the commission will investigate longer-term and more-sophisticated issues involved in quality health care. That will be a major way for this administration to begin to think about managing our programs in a very different way.

I do not believe that heavy front-end regulation of huge government programs should be done in the future. I do believe that we must use a quality mechanism of some kind as a new way of reconceptualizing how the government does its work and holds the programs and the money that we commit to higher and higher standards.

In April 1997, the President came to New York City to celebrate the 50th

anniversary of Jackie Robinson breaking the color line in organized baseball. New York was the place where Jackie Robinson made history; the place where he stood his ground and refused to give up. In many ways, that is what some of us are doing. In New York State and in New York City, which for millions of people was and is the promised land, Jackie Robinson fought for the promise of America. That is what all of us must always do. Like Jackie Robinson, Margaret Mahoney, and others, we have to remember our promises, and we have to keep them.

REFERENCE

1. Hertzlinger, R. *Market Driven Health Care.* New York: Addison-Wesley; 1997.